CAMP BASTION, Afghanistan (Oct. 5, 2011) An Antonov 124-100M cargo aircraft delivers one of three Magnetic Resonance Imaging (MRI) systems to the Role 3 Medical Facility at Camp Bastion, the first of its kind in the country. Naval Medical Logistics Command, Fort Detrick, Maryland had the lead role in acquiring the systems. (Royal Air Force photo by Sgt. Mitch Moore/Released).

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LOGISTICALLY *speaking*

On the Front Cover
CAMP BASTION, Afghanistan (Oct. 5, 2011) An Antonov 124-100M cargo aircraft delivers one of three Magnetic Resonance Imaging (MRI) systems to the Role 3 Medical Facility at Camp Bastion, the first of its kind in the country. Naval Medical Logistics Command, Fort Detrick, Maryland had the lead role in acquiring the systems. (Royal Air Force photo by Sgt. Mitch Moore/Released).

On the Back Cover:

At the Naval Expeditionary Medical Training Institute headquarters in Camp Pendleton, CA, Navy Expeditionary Medical Support Command deploys a partial Expeditionary Medical Field Hospital.

Naval Medical Logistics Command's Operational Forces Support Directorate, for the third year running, joined friends of the Fredrick County Action Agency (FCAA) to help, sort, package and prepare food for soup kitchens, homeless shelters, battered women shelters, and other worthy charitable organizations, December 15, 2011. Pictured from left to right: Cliff Dunlap, Warren Hyatte, Mark Weldon, Deniz Mackey, Tanzy Logue (Team Leader), Mike Schomer, Valerie Taylor, Charles Teague, Ross Mackey.

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From the Commanding Officer

Capt. J.B. Poindexter, III, NMLC CO

First off, let me welcome everyone into the New Year. Logisticians across Navy Medicine worked tremendously hard throughout 2011 and our customers and stakeholders reaped the benefits of all that was accomplished. We will all look forward to the recognition of those accomplishments at this year's Financial Management and Logistics Training Symposium.

One of the noteworthy accomplishments was the successful acquisition of three Magnetic Resonance Imaging (MRI) systems that were transitioned to their final destination in an active combat zone in Afghanistan. For those not familiar with all that went into this phenomenal feat, allow me to briefly highlight some of the challenges we faced in getting this job done.

No MRI had been in theater before so there was no existing infrastructure. Neither MRI technologists to operate the systems nor equipment technicians to maintain them were available. No roads were in place to support the weight requirements necessary to deliver the systems from one location to another. There were no electrical systems in place to support the equipment's consumption requirements . . . by now, I am sure you are getting the picture. In short, what would normally take upwards of two years, our staff accomplished in less than 12 months. We coordinated with planners and logisticians from around the globe, overcame seemingly insurmountable odds, and successfully placed in theater highly sensitive equipment that is designed to provide advanced diagnosis and treatment of mild traumatic brain injury.

In 2012, we will face special challenges as we are called upon to do more with less and achieve ever greater efficiencies in logistics support. For instance, we are now the business process owner for the contracting audit area in Navy Medicine's push to become audit ready in 2013. This will include assessing existing controls and determining the extent to which key control objectives are met as they relate to contracting. In very simple terms, we will be following the flow of funds from commitment to obligation, to goods or services received, and finally to close-out, to see if BUMED has the processes and systems in place to demonstrate that audit objectives have been met. This initiative will affect every contracting office across Navy Medicine.

These are the types of challenges 2012 hold for you but I know you are up to the task. As Vice Adm. Nathan says, "we must look intently at the value of what we provide [because] when the world dials 911, it is not to schedule an appointment." We have demonstrated that our products and services ensure that warfighters are first-in-line for receiving world class medical care.

I am sure that the logisticians across Navy Medicine are up to the task of continuing to provide that type of service – the type that is now expected of Navy Medicine -- and I look forward to supporting your every effort.

From the Command Master Chief

If I were asked in 1987, as a new Hospital Corpsman, what was Naval Medical Logistics Command's role, I would probably have said it dealt with delivering supplies to hospitals. However, after reporting for duty as the Command Master Chief in October 2011 and learning what Naval Medical Logistics Command actually does, all I can say is WOW!

The Commanding Officer often states, "we keep med gear at the tip of the spear." I couldn't agree more. That is exactly what Naval Medical Logistics Command does — and we do it quite well.

From coordinating the assemblage of medical materiel for five fleet TY-COM's; management and review of Authorized Medical/Dental Allowance Lists for our hospital ships; deploying expeditionary medical facilities to Kuwait, Djibouti or anywhere our Combatant Commanders see fit; assisting our Medical Treatment Facilities (MTF) with contractual advice and assistance for clinical staffing; delivering real time information on emerging technologies in the repair and maintenance of medical equipment within

HMCM(FMF) David L. Hall, NMLC CMC

our MTF's or the implementation, procurement, assemblage and delivering three Magnetic Resonance Imaging suites into Afghanistan are the remarkable achievements that keeps us in business.

Effective communication and collaboration within our command ensures our critical involvement to our partners, Fleet Forces command and Navy Medicine enterprise, while our dedicated staff members provide the level of expertise and experience unparallel to America's best and largest corporations.

Our 210 employees are comprised of active and retired military personnel and government and contracted individuals, who bring their technical knowledge, insight and wisdom in keeping our stakeholders, customers, constituents and most importantly, the war fighter, state-of-the-art medical materiel solutions abroad and near, 24 hours a day, 365 days a year.

Maintaining a sharp sense of duty calls for ingenious ways of developing a diverse Navy family within our command. Our Morale, Welfare and Recreation committee keeps us together at seasonal functions such as our Fall Festival, holiday functions and command events. The Wardroom, Chief Petty Officers Mess and the Petty Officer Association displays keen military bearing and tradition during base-sponsored events such as our annual Army vs. Navy flag football game, Navy ceremonial programs and at periodic food and bake sales.

We want to be the first call you make for assistance and advice. We want to be better at what we do so you, as our customer, receives the very best. We want to "keep the med gear at the tip of the spear!"

LOGISTICALLY *speaking*

Office of Counsel

"Dogs have no money. Isn't that amazing? They're broke their entire lives. But they get through. You know why dogs have no money? ... No pockets."
Jerry Seinfeld

Pockets (usually empty) are the key to many of the funding decisions within Navy Medicine. Let's say that you're an engineer or analyst and you've received a requirement from the customer. Do you first ask about the dollar value? You'd be amazed at the number of procurements valued at $249,999 (or thereabouts). Certainly, that wouldn't be to avoid the dreaded "OP" term (a pocket which is almost always empty) ...

Reading this article won't negate the need to occasionally need Other Procurement (OP) funding or to request a legal opinion on the appropriate funding. However, it may make the process less daunting since you'll have some information available. Why should you be concerned about drawing money from the correct pocket? According to the DoD Financial Management Regulation, improper OP/Operations & Maintenance (O&M) categorization is the #3 cause of potential Anti-Deficiency Act violations.

Definitions

Expenses are those "[c]osts of resources consumed in operating and maintaining the DoD". Expenses are funded with O&M funds. (Reference DoD Financial Management Regulation, Volume 2A, Chapter 1). Typically, consumable items, civilian salaries, equipment maintenance, travel, and training will fall into the expenses (O&M) category. Investments by contrast are those"[c]osts to acquire capital assets such as real property and equipment". Investments are funded with Other Procurement

(OP) funds. (Reference DoD Financial Management Regulation, Volume 2A, Chapter 1). Common examples of investments may include equipment production.

System Unit Cost

What should be considered in the cost of a particular requirement? When determining system unit cost, there are three major categories:

New systems, i.e., the items constitute one documented requirement – the system unit cost includes the cost of all components (the entire requirement).

Changes to or additions to existing systems in order to correct issues or improve performance – the aggregate cost of the new items equals the system unit cost.

Individual items, or changes to/ additions to existing systems but the items aren't considered a system (see category #1 above). The system unit cost equals the cost of each individual equipment item.

Determination of Expense/ Investment

We need to apply the expense/ investment determination to establish the correct funding for a given requirement. This determination considers the documented requirement and is made on a case-by-case basis.

The basic rules, applicable to Navy Medicine (excluding DWCP), are as follows:

Is the item subject to centralized item management and asset control? In other words, are decisions concerning this item made elsewhere, such as an inventory control point (ICP), rather than at your local command?

If Yes: Classified as an Investment, funded with OP

If No: Proceed to threshold question

Does the item exceed the $250K threshold?

If Yes: Classified as an Investment, funded with OP

If No: Classified as an Expense, funded with O&M

LOGISTICALLY *speaking*

As always, the facts are key to any expense/investment determination. Let's address a few commonly occurring questions:

Supplies

Consumable supplies are funded in the O&M appropriation, with the exception of those supplies purchased as part of an initial outfitting (see below).

Commercial Off the Shelf Items (COTS)

This determination will be based on the system unit cost. The fact that the requirement can be met with a COTS does not automatically equate to an O&M determination.

Transportation

Transportation will be funded within the associated appropriation, matched with the underlying equipment item. However, it is not factored in to the system unit cost. For example, if the equipment met the investment criteria above, the transportation will also be funded with OP. However, the transportation will not be calculated into the system unit cost to determine whether the requirement exceeds $250K.

Installation (including re-installation)

Installation costs are also not factored in to the system unit cost. If supporting an investment item, the installation of that item will also be considered an investment. Provided that a MILCON project is not involved, the installation may be either an expense or investment depending on the underlying item. However, re-installation is considered to be an expense.

Leases

Typically, the payment for an equipment lease is considered an expense, funded with O&M. However, it is critical to know whether the lease is an operating lease or capital lease. Many leases utilized in Navy Medicine are operating leases for a period of performance of 12 months or fewer. In an operating lease, the Navy has the right to use or operate the equipment, but does not own the equipment; these are funded as expenses. By contrast, capital leases fit within investments since ownership may be transferred to the Navy or there may be a Navy right to purchase. The value of the lease may result in a capital lease as well; for instance, if the price of the lease exceeds 75% of the "estimated economic life of the leased property" (Financial Management Policy Manual, 075001) this will equate to a capital lease.

Trade-in allowances

The trade-in item relates back to the original appropriation used. As an example, if the equipment is properly funded with O&M, the trade-in value is in the same appropriation. It should be noted that trade-in items carry the same funding availability as the original funding. As an O&M trade-in, the period of availability remains one year (from the start of the applicable fiscal year, not the date of the trade-in). Beware: the trade-in value does not offset system unit cost.

Maintenance

Maintenance preserves existing equipment, but does not change or improve equipment. This is regularly included as an expense, budgeted with O&M. One major exception to the general rule occurs when the equipment maintained is solely in support of RDT&E efforts. In that instance, the maintenance will be funded with RDT&E.

Equipment modifications and technology refreshment

Modification of an investment equipment item is also considered to be an investment. Modification is essentially any change to including modernization of equipment end items. The modification will change or improve various characteristics. This should be contrasted with maintenance which merely preserves functionality/operability of the existing equipment.

We all know that technology generally improves over time. When you upgrade software, it may be impossible to buy the identical product because the manufacturer has likely improved the features.

Items such as software are considered to be expenses, as they are part of the day-to-day operations of a command. When one goes to purchase the replacement item and the item suddenly affords the command improved capabilities, does that render it an investment? Not automatically, if the item through mere timing has extra bells and whistles, this is through no fault or requirement of the requiring activity. As the same underlying item is required, then this would also be viewed as an expense (which equates to O&M funding). If we require upgraded capabilities, or our underlying needs have changed, e.g., new facility, increased system needs, etc., any upgrade will be considered to be an investment (OP). The key is whether the "performance envelope" would be substantially impacted; if so, this is beyond O&M and must be funded with OP.

Initial outfitting

If a capital asset such as a fixed facility or ship must be initially outfitted, the items which may usually be considered expenses if purchased separately (low value consumables and equipment) will be considered as part of the total cost of the investment, in other words, funded with OP. The key question is: what is needed to run the facility? sail the ship? etc. Those items are considered as part of the initial outfitting. Items which are later procured will be budgeted as expenses. Requirements should not be split in order to avoid procuring all items with OP funds; those truly required for initial use/operation (part of the initial outfitting) may be procured separately from those that genuinely arise later (replacement equipment, etc.).

In short, the above address common examples, but each determination must be made on its facts. Consider contacting the Office of Counsel, NAVMED-LOGCOM on a particular funding question.

Now, a holiday wish for some OP (and O&M) funding to fill those empty pockets.

CLINICAL ENGINEERING

The CE support division is involved with numerous projects, with several major initiatives ramping up during this fiscal year. These projects include: putting magnetic resonance imaging (MRI) systems into theater; equipping all Naval facilities with real-time location systems (RTLS); equipping several Navy medical treatment facilities (MTFs) with pharmacy automation; and beginning a number of strategic sourcing initiatives.

MRI's in Theater

Since late December 2010, NMLC has been working to provide the contracting and logistical support to deliver magnetic resonance imaging (MRI) systems to Afghanistan. Clinical Engineering division's support of this initiative has included weekly, even daily, phone calls with the equipment vendor and theater personnel to coordinate system delivery, off-loading, maintenance support and acceptance testing. After ten months of planning, three MRI systems have been delivered into Afghanistan and are currently operational.

Pharmacy Automation Update

The pharmacy automation requirement is currently in the procurement process and industry proposals are currently being evaluated.

Strategic Sourcing Initiatives Update

NMLC is working to identify commodities that will benefit from strategic sourcing initiatives. According to the NMLC Acquisitions Directorate, strategic sourcing centralizes commodity management but permits local contract execution. This drives cost savings, purchase efficiency and allows product standardization. Initial candidates for strategic sourcing are orthopedic implants, endoscopes, and maintenance. NMLC has also been assisting DLA Troop Support with a DoD-wide initiative for strategic sourcing of laboratory equipment and reagents.

Staff Changes

The Clinical Engineering team is excited to welcome four new engineers to the fold, so don't be alarmed if you start seeing new names requesting information on medical equipment requirements.

Anthony Metzger has been with the team for over six months and has worked on several optometry/ophthalmology projects as well as generating technical data packages (TDPs) to move Navy Medicine requirements into the procurement process.

Kimberly Conley, Saba Getachew, and Adam Belanger recently joined the team. They will also be assisting with the generation of TDPs.

Anthony Angelo, Kim Hernandez, Erin Blair, and Leora Duggan (formerly Leora Frank) continue to work on special projects and the centralized maintenance contracts, as well as general CE duties.

The CEs are realigning specialty areas with the addition of new staff but are always standing by to assist with requirements definition, market research, or other questions.

Any general questions, concerns, or comments can be sent to our team e-mail: NMLC-CE@med.navy.mil.

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LOGISTICALLY *speaking*

REAL-TIME LOCATION SYSTEMS (RTLS)

By Erin Blair

The RTLS project is an effort to achieve total asset visibility to ensure appropriate equipment utilization, meet preventive maintenance goals, and reduce unable-to-locate (UTL) equipment. Navy Medicine is seeking to acquire the ability for a RTLS for asset tracking/management to supplement the automated information logistics system, Defense Medical Logistics Standard Support (DMLSS). Initial RTLS requirements will focus on asset tracking to facilitate preventive maintenance and inventory management. RTLS will add another tool for BIOMED, equipment and materials management, and clinicians to manage assets. The ability to access and track assets throughout facilities is vital to ensure timely scheduled preventive maintenance, accurate inventory capture, and efficient allocation of assets for patient care.

> *"The capability to access and track equipment throughout the facilities is vital to ensure timely scheduled preventive maintenance, accurate inventory capture, and efficient allocation of assets for patient care."*

MARKET RESEARCH

NMLC advertised a request for information on FedBizOpps in October 2011 in order to survey the market relative to Navy Medicine's potential requirement. A solicitation was posted with a basic set of requirements as well as a sample MTF. Vendors were invited to submit proposals to be selected for presentations at NMLC's RTLS Industry Day . Eight vendors were selected to represent a broad range of solutions and were invited to give presentations to Navy Medicine representatives from NMLC, NAVMEDWEST, NAVMEDEAST, Navy Medicine Information Systems Support Activity (NAVMISSA), and BUMED. Additional market research has been performed at recent conferences, including the Healthcare Information and Management Systems Society (HIMSS) and Association for the Advancement of Medical Instrumentation (AAMI).

REQUIREMENTS DEFINITION

RTLS requirements are being defined based on previous equipment request packages submitted by the MTFs as well as information gathered from other subject matter experts and market research. Once the requirements are defined, a statement of work will be finalized and reviewed by relevant parties to ensure that the needs of the Navy Medicine community are met. In order to assist with requirements definition, NMLC performed site visits at currently installed RTLS projects at Brooke Army Medical Center and Keesler Medical Center at the end of November 2011.

GOVERNANCE PROCESS

In concert with defining the requirements, RTLS is going through the Navy Medicine IT governance process. RTLS is currently in Step 7, which means that the request has already been reviewed and approved by the Capabilities Management Work Group (CMWG) and is now being reviewed by NAVMISSA. NAVMISSA will develop an analysis of alternatives (AOA) and total cost of ownership (TCO) in preparation for presentation to the Management Control Board (MCB).

NEXT STEPS

NMLC will continue to develop the statement of work in order to move the request into the acquisition process once MCB approval is obtained.

Any general questions, other concerns, or comments can be sent to Erin Blair at erin.blair@med.navy.mil.

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Imaging Informatics

Navy PACS Office

IHE integration profiles support: A key factor in PACS

A Picture Archiving and Communications System (PACS) provides storage of, and access to, medical images from multiple modalities. Radiologist reports are also stored and transmitted through the PACS. Digital Imaging and Communications in Medicine (DICOM) is the universal format for images that are stored and transferred in PACS. A PACS has four major components: imaging modalities such as computed tomography (CT), ultrasound, mammography, and magnetic resonance imaging (MRI); a secure network for the transmission of patient information known as the Hospital Information System (HIS) and the Radiology Information System (RIS); workstations for reviewing and interpreting images; and archives for the storage and retrieval of images and reports. There are multiple PACS from different vendors deployed throughout DOD Medical Treatment Facilities (MTFs) both within the Continental United States (CONUS) and overseas.

Currently, the Composite Health Care System (CHCS) is the HIS used at DOD MTFs. It is module based, with modules for radiology, pharmacy, laboratory, patient scheduling, patient administration, medical billing, etc. The Armed Forces Health Longitudinal Technology Application (AHLTA), formerly known as CHCS II, is the electronic health record (EHR) utilized by Navy MTFs. It is the DOD medical and dental information management system and is used by healthcare providers to document progress notes, place orders, document procedures performed, etc. It also provides secure online access to all military health system beneficiaries' records for providers. AHLTA links the MTFs, including those that are deployed abroad, to the EHR.

Those are some of the healthcare information technology (HIT) systems that reside within the various MTFs. It is important that these systems interact with each other seamlessly to ensure efficient patient care. This is why integrating the healthcare enterprise is important.

Integrating the Healthcare Enterprise (IHE) is an initiative by industry and healthcare professionals to improve the way computer systems in healthcare share information. IHE brings together healthcare IT stakeholders to implement standards for communicating patient information throughout the healthcare enterprise by developing

Imaging Informatics Mission

Develops the strategic vision for, and executes the Imaging Informatics Program for Navy Medicine which includes successful and coherent planning, deployment, integration, sustainment and life-cycle management to the greatest clinical and financial benefit possible. Provides support to internal and external customers for Medical Equipment Information Assurance.

MEDICAL IMAGE MANAGEMENT

The production of visual representations of body parts, tissues, or organs, for use in clinical diagnosis; encompasses x-ray methods, magnetic resonance imaging, single-photon-emission and positron-emission tomography, and ultrasound.

Imaging Informatics

Navy PACS Office

IHE integration profiles support: A key factor in PACS

(Continued from page 10)

a framework for interoperability. Because of its proven process of collaboration, demonstration and real-world implementation of interoperable solutions, IHE is in a position to significantly accelerate the process for defining, testing and implementing standards-based interoperability among EHR systems.

Instead of creating new standards, IHE drives the adoption of existing standards to address specific clinical needs. This is accomplished by using IHE Integration Profiles. These profiles provide precise guidance on how standards are to be used to address clinical needs, eliminate ambiguities, reduce configuration and interfacing costs, and ensure practical interoperability. Before the IHE initiative, there was no agreed upon method for the various systems utilized within radiology to work together to manage patient care situations. Now, there are IHE Radiology Integration profiles that can be used to ensure interoperability among the various systems. To ensure that every PACS deployed at Navy MTFs is able to support the IHE initiative, the Imaging Informatics Division of NMLC requires a vendor to demonstrate which IHE Radiology and IT integration profiles are supported by their system when they respond to requests for proposals. This ensures that the system selected can easily integrate with other systems within the MTF allowing healthcare providers easier access to the patient information that they need in order to provide the highest quality of care.

In the current environment, where interoperability between different systems within the healthcare enterprise is paramount, the Imaging Informatics Division is making sure that the Navy PACS program is in line with the IHE initiative, resulting in unparalleled patient care delivered to our customers.

LOGISTICALLY *speaking*

EQUIPMENT MANAGEMENT & ANALYTICS SUPPORT TEAM

Fiscal Year 2012 kicked off with a very successful Equipment Management (EM) Workshop attended by both seasoned and novice Equipment Managers, resulting in an energetic discussion of policies, procedures, and best-practices.

The monthly EM teleconference was also revived. During the teleconference, NMLC emphasized the end-of-year review of the following DMLSS reports:

- *Annual Capital Asset Balance Report*
- *Annual Capital Equipment Depreciation Report*
- *Annual Capital Equipment Gain and Loss Report*

In addition, Equipment Managers must review the following monthly reports to ensure that capital equipment are appropriately gained and disposed of using DMLSS:

- *Monthly Capital Asset Balance Report*
- *Monthly Capital Equipment Depreciation Report*
- *Monthly Capital Equipment Gain and Loss Report*

Lastly, the FY12 Logistics Guidance is now available on the NMLC website. For any questions on the ETM policies in the Logistics Guidance, please contact nmlc-etm@med.navy.mil.

FY12 Logistics Guidance Equipment Management Highlights

On October 31, 2011, the FY12 Financial and Logistics Guidance was signed and issued for implementation and execution. Equipment Managers must review the FY12 Logistics Guidance as it contains the most current guidance in the areas of Property Accounting & Equipment Management. Below are the highlights of the FY12 Logistics Guidance affecting the Equipment Managers:

1. Submission of Command-Funded requisitions to NAVMEDLOGCOM
2. Equipment Replacement Criteria
3. Leased and Cost-Per-Test Equipment
4. Use of standard nomenclature
5. Equipment Procurement Review Committee (EPRC)
6. Walkthrough of Patient Care areas
7. Walkthrough of Non-Patient Care areas
8. Annual review of Equipment Management Plans
9. Capital Equipment Reports
10. Affixing of linear and 2D barcodes
11. Document Management
12. Custodianship of IT Equipment
13. Custodianship of Clinical/Health IT Equipment
14. Accounting of ADP Equipment
15. Disposal of Computer Equipment
16. System-Component Relationship
17. Unique Identification
18. Equipment Loan
19. Lateral Transfer of Equipment
20. Automated Neuropsychological Assessment Metrics (ANAM) computers
21. Custom Magnification Loupes
22. PACS and DDI Systems
23. Active Directory Servers
24. Patient Movement Items Tracking System (PMITS)
25. Review of EM Reports

EM REMINDERS

- Review the FY12 Logistics Guidance
- Review DMLSS reports for capital equipment
- Retain transaction documents for financial auditing
- Review Monthly Quality Assurance Reports from the NMLC website
- Submit SAAR-N Forms for DMLSS-EM access
- Properly dispose equipment thru reutilization and excess reporting
- Participate in the EM Defense Connect Online (DCO) Training on 9 Feb 12

FY12 Logistics and Acquisition Guidance

The FY12 Logistics and Acquisition Guidance is now available at the NMLC website (CAC required):

https://gov_only.nmlc.med.navy.mil/guidance.asp

NMLC BIOMED Management Workshop participants visit Walter Reed NMMC

Photos by Eric Elane

NMLC conducted a 5-day BIOMED Management Workshop during October 17-21, 2011, which was attended by BMETs from Walter Reed National Military Medical Center (WRNMMC), NH Beaufort, NHC Charleston, Navy Marine Corps Public Health Center (NMCPHC), and the Navy Medicine East (NME) Regional BMET Representative. The workshop covered topics like cost-benefit analysis, technical review of procurement packages, EPRC, acceptance inspections, maintenance plan & procedures, work order management, processing of UTLs, monitoring of service contracts, review of management metrics and reports, as well as creation of business objects template. The workshop also included a site visit at WRNMMC with HMC Fernando Trujillo, WRNMMC BIOMED LCPO, facilitating the tour.

BETHESDA, Md.—The NMLC BIOMED Management Workshop participants visiting the new BIOMED shop at WRNMMC. Standing from left to right: HMC Fernando Trujillo (*WRNMMC*), HM1 Jetendra Rampersaud (*WRNMMC*), HMC Casey Payne (*NMLC*), Mr. Eric Lawrence (*NMLC*), HM1 Bill Ross (*NMCPHC*), HM1 Eric Demler (*NH Beaufort*), HM1 Sean Buckley (*NME*), Ms. Elizabeth Erdman (*NMLC*), HM2 Rowell Pasion (*NMLC*), and HM2 Miguel Burgos (*WRNMMC*). Sitting from left to right: HM2 Andre Larondelle (*NHC Charleston*), HM1 Darwin Toledo *(WRNMMC)*, and HM1 Sherwin Villagracia (*NMLC*). Not in the picture is Mr. Eric Elane, who was taking all these photos.

BETHESDA, Md.—HMC Trujillo conducts a brief introduction of their BIOMED operations and the challenges involved with the ongoing BRAC process and the resulting influx of maintenance-significant equipment from the Walter Reed Army Medical Center (WRAMC). BIOMED will be relocating from the basement to the 2nd floor of Building 5 (America Bldg) beginning December 2011.

BETHESDA, Md.—BMETs need to be aware of the existing technologies their commands are capable of providing and ensure that they are able to support these equipment by including technical training as part of their command's maintenance strategy. Mr. Morgan Silva (*WRNMMC*) presents their patient monitoring system used in one of their 100% private inpatient rooms.

NMLC is planning to conduct a quarterly BIOMED Management Workshop to accommodate the various availability of participating Commands. Contact Ms. Elizabeth Erdman for inquiries or registration.

BETHESDA, Md.— Among the areas that the workshop participants visited was Nuclear Medicine department (top right), where the Linear Particle Accelerators (LINACs) are located, and the Amputee Center (middle right and bottom right). The Amputee Center that moved from WRAMC includes a CAREN lab (middle right), which simulates walking on different surfaces, and a gait lab to simulate movement and evaluate a patient's walking motions to better design a custom prosthetic.

BIOMEDICAL EQUIPMENT DIVISION SUPPORT

*** REMINDERS ***

1. **BMET of the Year Application.** An email was sent out from NMLC concerning BMET of the Year applications that needs to be completed by 16 Jan 2012. Nomination Forms were disseminated to all, if there are any questions or concerns, contact HMC Payne at casey.payne@med.navy.mil.

2. **X-Ray Acceptance Training.** The Medical Education and Training Campus (METC) Biomedical Repair Technician Program is now accepting registration for the Radiographic Acceptance Procedures course. Classes will convene on 22 Feb 2012 and on 06 Jun 2012. Eight seats are available for Navy BMET's per class. For additional information, contact HMC Carter at cody.a.carter.mil@mail.mil .

3. **NMLC BIOMED Website**. Please take time to look at the newly revised content for the BIOMED section of the NMLC Website. There is a link on the webpage for suggestions and feedback.

The Blown Fuse

NMLC is reviving the **Blown Fuse** and we need suggestions and content contributions. This BIOMED Newsletter is our publication to share and disseminate information throughout the community. This can include troubleshooting tips, better business practices, accomplishments and shop photographs. Send your ideas and content contributions to NMLC-ETM@med.navy.mil.

4. **Centrally-procured test equipment.** In September 2011, NMLC procured test equipment for several sites. The BIOMED Support Team is required to verify the receipt of the test equipment. An email with a template concerning the ordered test equipment was included. If there are any questions concerning this, please contact HMC Payne at casey.payne@med.navy.mil.

Description	Manufacturer	SITES
SC-5 + OxSlim Kit	Pronk Technologies Inc.	All NMC/NH except NNMC
90XL Dialstat Analyzer	Mesa Laboratories	NMCP
Scopemeter	Fluke Corp.	Large MTF's
90XL Gas Analyzer	Riken	NMCP
ECC X-Ray Pulse Counter / Exposure Time Meter	Electronic Control Concepts	All NMC/NH
Piranha Premium Ortigo/MAS-2/QAB	RTI Electronics Inc.	All NMC/NH except NNMC
Piranha R&F/M 655	RTI Electronics Inc.	All NMC/NH except NNMC
Impulse 7000DP w/test automation	Fluke Corp.	All NMC/NH
RF 303RS Digital Electrosurgery Analyzer	Fluke Corp.	All NMC/NH
Star Dental Simulator Gauge	Star Dental	All NMC/NH
Line Power Meters	Dranetz-BMI	All NMC/NH

BIOMEDICAL EQUIPMENT DIVISION SUPPORT

MONTHLY MANAGEMENT REPORTS

The monthly management reports are administrative tools that BIOMED utilizes to analyze the monthly workload. When reviewed and acted upon, these reports help the improve efficiency of the BIOMED Shop. The LPO or designated PO is required to review the following reports in DMLSS:

Unable to Locate Report lists all equipment not found during the month of scheduled maintenance. Actions are required to be implemented prior to the end of the month.

Equipment without A Maintenance Activity lists all maintenance-significant equipment that do not have an assigned BIOMED shop.

Equipment without a Maintenance Plan lists all maintenance-significant equipment that do not have maintenance intervals.

Maintenance Interval without Due Date Report lists all equipment that has a maintenance plan but does not have a due date for each regular scheduled type of maintenance.

Suspended Scheduled Work Order lists all scheduled work orders that have not been completed and were suspended. Suspending of work orders are generally discouraged by NMLC.

Maintenance Management Report is a metric tool for workload management. This measures the amounts of work orders; new, scheduled or unscheduled, as well as the labor hours for indicated month and previous months. BIOMED's monthly preventive maintenance completion rate is calculated from this report.

CONGRATULATIONS SHIPMATES!!

Kudos to the following BMETs who were selected for advancement for Cycle 212:

HM1 Janelle Cline
NH Jacksonville

HM1 Xavier Perez-Mendez
NHC New England (Incoming)

HM1 Gabriel Sanchez
NH Camp Pendleton

HM1 Anna Anderson
NH Camp Pendleton

HM1 Alvaro Benitez
NH Pensacola

MATERIAL MANAGEMENT BRANCH
Prime Vendor Generation IV

The Prime Vendor Generation (Gen) IV contracts were awarded on 04 April 2011. Extensive systems development and integrated testing to support Gen IV upgrades must take place prior to implementation. Contracts will transition from Gen III to Gen IV beginning March through June of 2012, one global region at a time. Refer to the map below for identifying the global region your command falls under.

Regional Training for the South will be held at San Antonio, TX in March 2012 and go-live is set for April 2012.

Regional training for the North will be held at Fort Detrick, MD in April 2012 and go-live is set for May 2012.

Regional training for the West will be held in San Diego, CA in May 2012 and go-live is set for June 2012.

All sites will be notified about the training dates and are encouraged to attend.

Any inquiries can be sent to Etta Ingram at etta.ingram@med.navy.mil.

Regional Training/Train-the-Trainer (TTT) instruction will occur at three regional sites (San Antonio, TX, Fort Detrick, MD and San Diego, CA) and include the following business processes specific to GEN IV:

- Supply Chain Overview
- Contract Overview
- Enhanced Catalog Data
- Universal Data Repository (UDR) Update
- Maintain/Search Catalog
- New Item Request (NIR)
- Discrepancy Process
- Trading Partner Information
- Primary and Backup Prime Vendors Holding Backorders
- Delayed Delivery
- Real-time Price Verification
- Master Ordering Facility (MOF)
- Wide Area Work Flow (WAWF)
- Prime Vendor War Reserve Materiel (PV WRM)
- Ordering Return Authorization
- Fill Rate

Medical/Surgical Prime Vendor Regions - Generation IV
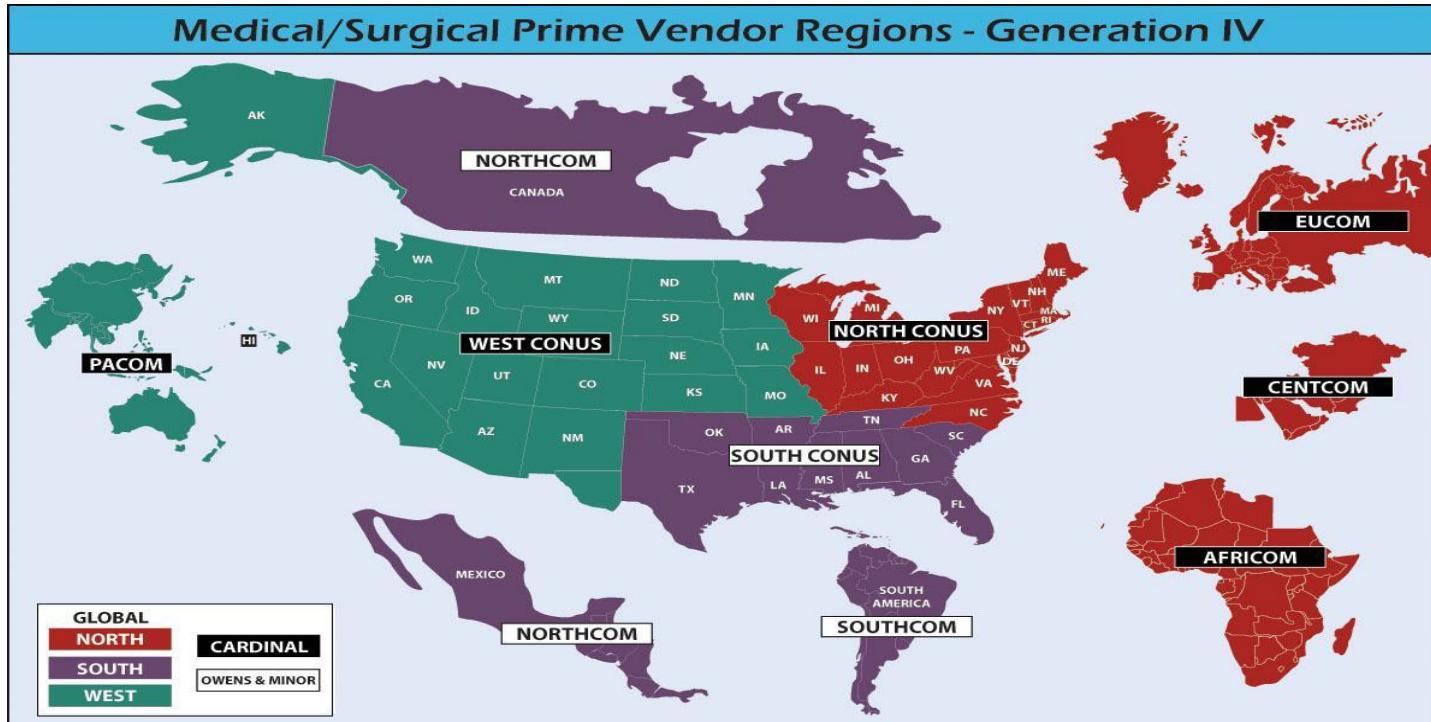
LOGISTICALLY *speaking*

MATERIAL MANAGEMENT BRANCH

DLA-TS announces removal of Japanese Encephalitis Vaccine

from Prime Vendor Catalog beginning January 2012

D efense Logistics Agency - Troop Support (DLA-TS) promotes and facilitates the transition from traditional defense depot support to e-commerce whenever this business strategy reduces the delivered costs, improves service reliability or reduces the logistics response time. But there are circumstances where the defense depot support model makes both better logistics and business sense. Such is the case with the Japanese Encephalitis Vaccine Ixiaro®.

In Fiscal Year 2011, there had been a growing trend in obtaining Ixiaro® through the Prime Vendor Program. Last year, 62% of all orders for this product were sent to the Prime Vendors with the remaining 33% being sent through MILSTRIP. The combined action of DLA-TS to rely more heavily on the Prime Vendors resulted in an additional $117,000 in delivered costs, put upward pressure on the depot standard price, and complicated the tasks of supply/demand planning for the depot stocks. More importantly, a significant number of customers experienced product losses due to lapses in appropriate cold chain management.

After reviewing the facts, DLA-TS have concluded that the optimum business model for support of this unique vaccine is the traditional depot system. Therefore, Ixiaro® will be removed from the Prime Vendor catalog beginning January, 2012, and DLA-TS will actively assist customers in sourcing all future orders through MILSTRIP. This will increase the reliability of delivering a usable vaccine to customers and reduce overall delivered costs. Unfortunately, these cost reductions will not be evenly shared. CONUS customers that were ordering from Prime Vendors will pay around 12% more while OCONUS customers will pay approximately 22% less, with a combined effect of reducing total delivered costs by around $117,000/year. Once a reliable demand/supply chain is reestablished, DLA-TS expects to leverage the increased purchasing power for depot stocks to lower product costs for all customers.

The DLA-TS point of contact for this effort is Commander Jay Peloquin at jay.peloquin@dla.mil or (215) 737-2839. He is standing by to provide the business intelligence used in arriving at the conclusions outlined above and for any additional questions. The Customer Pharmacy Operations Center of DLA-TS will be advising their counterparts at all Military Treatment Facilities and other ordering activities of this pending action. In addition, customer account specialists will be assisting all affected customers in modifying their sourcing logic to point all future orders to MILSTRIP.

MATERIAL MANAGEMENT BRANCH
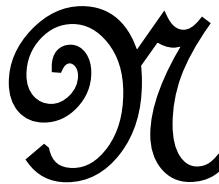
N MLC's Medical Equipment and Logistics Solutions (MELS) Directorate manages the centrally funded Seasonal Influenza Vaccine Program. The Defense Logistics Agency – Troop Support (DLA-TS) serves as the primary distribution center for all injectible Influenza Vaccine for DoD. Vaccine is shipped from the manufacturer to DLA-TS where it is processed, repacked into the service location allotments, and shipped to the MTF and/or ordering location. Intranasal Influenza Vaccine is shipped directly from the manufacturer, MedImmune, with DLA-TS oversight of the requisition and release process to include cold chain management .

This process is broken down into four phases:

1. Requirements (Dec-Jan)
2. Solicitation (Jan-Apr)
3. Contract (May-Jul), and
4. Shipment (Aug-Jan)

 NOTE: *All timelines are subject to change each year.*

Any general questions, other concerns, or comments can be sent to Louise McLucas at sarah.mclucas@med.navy.mil.
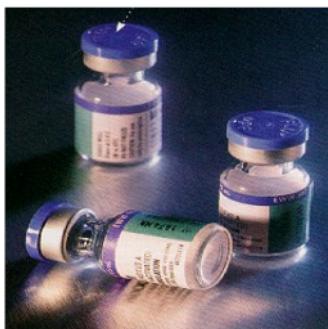
Seasonal Influenza Vaccine Distribution Process

Requirements Phase

1. *December* - Data Call. U.S. Navy and U.S. Marine Corps activities submit requirements via the NMLC web application Vaccine Information and Logistics System (VIALS). http://gov_only.nmlc.med.navy.mil/int_code03/vials/.

2. *January* - DoD requirements are reviewed, approved and forwarded to the Military Vaccine Agency (MILVAX) and DLA-TS

Solicitation Phase

1. *January* - DLA-TS issues solicitations to vendors
2. *February* - DLA-TS closes solicitations
3. *March* - DLA-TS receives offers
4. *April* - DLA-TS completes evaluations of manufacturer offers

Contract Phase

1. *May* - DLA-TS awards contracts and distributes contract information to Service reps

   - NMLC receives funding to centrally purchase vaccine
   - Service rep updates VIALS with contract data and service priorities

2. *July* - VIALS generates MILSTRIP

   - Service rep forwards requisitions to DLA-TS which are immediately put on backorder status

Shipment Phase

- Shipments will occur in August to January timeframe
- VIALS matches shipments to orders and tracks shipments

Chief Hospital Corpsman Carries Unique Distinction

Hospital Corpsman Chief (SW/AW) Casey R. Payne is Naval Medical Logistics Command's Senior BMET Representative to the Navy MTFs

By Julius L. Evans, NMLC PAO

Aboard *USNS Comfort*, Chief Casey R. Payne discusses with HM1 Jon Strong, HM1 Keith Skelley and HM1 (SW/AW) Rex Valencia the radiation calibration testing procedures being implemented by the Department of Defense.

Eric Elane

Navy hospital corpsmen have long played unique roles in providing high quality healthcare for uniformed service members and retirees at Military Treatment Facilities (MTF) around the world. They are engaged in all aspects of expeditionary medical operations in support of Warfighters and ensure Sailors, Marines and other users of the Military Health Systems are medically prepared to meet their worldwide missions. A significant part of that readiness depends on top-quality medical equipment that is operable and ready-to-go at any moment.

According to the Bureau of Medicine and Surgery's Equipment Management Manual, Naval Medical Logistics Command, Fort Detrick, Md., has oversight of all biomedical equipment maintenance programs in the United States Navy. The Biomedical Equipment Maintenance Division at each Navy MTF ensures all medical equipment works and meets appropriate established standards.

Biomedical equipment technician and clinical engineering roots can be traced back to the early 1970s. Noted consumer advocate Ralph Nader published an article that brought the medical industry to a state of frenzy, claiming that 1,200 people annually died from electrocution in hospitals from malfunctioning medical equipment. Seeking to provide maintenance and electrical safety testing of medical devices, a new discipline was essentially created to manage tasks such as changing defective electronic or mechanical parts or calibrating medical devices to assure they functioned properly.

Today's medical technology is far more advanced than 41 years ago. Vacuum tubes have been replaced with solid state devices and integrated circuits; logic circuits have been replaced with computer programs and applications. The functional safety requirements remain the same, but risk assessment is now a more prevalent maintenance management strategy to discover the equipment's inherent probable or hidden failures.

Navy Biomedical Equipment Technicians (BMETs) are not only expected to do bench work on medical devices but are also expected to manage the medical equipment throughout its lifecycle. They understand both the clinical applications and the electromechanical functions of medical devices. Moreover, they understand that the functional safety of medical technologies is based on three fundamental characteristics inherent in all medical devices -- accuracy, precision and reliability.

Comparably, an individual at Naval Medical Logistics Command inherently displays the characteristics described above and has a couple of

Julius L. Evans

more accolades to her credit.

Hospital Corpsman Chief (SW/AW) Casey R. Payne is Naval Medical Logistics Command's Senior BMET Representative to the Navy MTFs. She provides Navy-wide guidance for the effective implementation of policies and procedures governing medical equipment and maintenance for 33 Navy MTFs, four Naval Medical Research Commands and the Navy and Marine Corps Public Health Center. Additionally, she works in conjunction with the BMET (NEC 8410) Enlisted Technical Leader, the BMET Representatives at Navy Medicine East, Navy Medicine West, and other operational entities ensuring the free flow of communication to all BMETs. She is essentially the hub for critical information that impacts all BMETs.

Payne also carries one other unique distinction. Although the United States Navy has about 340,000 active and 128,000 reserve members on its rolls, she is currently the Navy's only female chief who actively carries the NEC 8410. In fact, of the 303 Navy BMETs, only 18 are female.

However, she does not belabor this distinction. "BMET, as a classification, is a multifaceted career field that encompasses multiple occupations within the Navy. First and foremost we are Sailors, then Corpsmen and finally Biomedical Equipment Technicians," she explained. "As far as our technical compatibility to other Navy Enlisted Classifications, we have the aptitude for electronics, electricity, plumbing, information technology, logistics, and basic-to-advanced radiology."

Considering the multitude of equipment and medical devices that fall within the range of disciplines listed above, clearly, qualified technicians are needed to manage the functional safety of medical technologies. The requirement for maintenance and equipment safety assures correct equipment voltage regulation, correct

calibration and all other aspects associated with properly maintaining operable life saving equipment.

Defibrillators, for instance, provide specific charges to ensure a heart receives the precise voltage in emergency situations. Improperly maintained, they could be rendered useless and in a worst case scenario may result in death or injury to a patient. Likewise, an improperly calibrated electrical surgical unit, the equipment doctors use to cut flesh, has the potential to cause severe patient burns or a fire in an operating room. Another example is something as common as a radiographic system. One exceeding the recommended amounts of radiation could expose a patient to an unnecessary dose of harmful radiation.

"BMETs are the little known but integral part of the hospital corpsmen field. We are proficient and maintain our role as Corpsmen but maintain all medical equipment vital to the

Pausing a moment during a recent meeting in the Naval Medical Logistics Command's conference room, Chief Payne leads the discussion with senior enlisted personnel: seated from left to right, HMC John McGilvery, HM1 Sherwin Villagracia, HM1 Jason Upchurch and HM1 James Williams.

Julius L. Evans

functionality of life," Payne explained. "Our impact to the Warfighter and the enterprise is the continuous preventative maintenance of medical equipment to support life saving efforts for Sailors, Soldiers, Airman and Marines."

Somewhat mimicking that old common recruiting slogan, Payne explained that the BMET field is 'looking for a few good men' and women. "We are critically undermanned and in light of the Navy manpower changes currently involving many ratings, I want to encourage my fellow shipmates to take a look at the biomedical equipment technician enlisted classification," she said. "To become a BMET, a candidate must graduate from Hospital Corps "A" School and be accepted into the Biomedical Equipment Technician "C" School."

In addition, Payne explained why considering changing to the BMET field could be beneficial. "Our specialty establishes professionals for follow-on careers in a variety of fields, including medicine, electronics, information technology, logistics and radiology to name a few," she said. "While maintaining the highest medical equipment maintenance technologies for military service members while on active duty, they could be well positioning themselves for meaningful careers after leaving the service."

Maintaining high-tech medical equipment will remain the primary job of BMETs because high quality health care for uniformed service members and retirees has always been a priority of the military services. Chief Payne exemplifies the commitment, dedication and professional technical expertise of the hospital corpsman and BMETs charged with maintaining high quality care in MTFs around the globe.

The Cake Whisperer

By Julius L. Evans, NMLC PAO

At any given time at Naval Medical Logistics Command, a walk through the kitchen area might lead one to a more and more common treat these days. Lt. Cmdr. Lydia Robinson has a passion for baking and often shares her creations with anyone with a taste for sweets. We asked her a few questions about herself and her hobby.

Would you be flattered to be called The Cake Lady?
I actually call myself The Cake Whisperer because I can make a cake do what I want it to do but Cake Lady is fine.

How did you start baking?
My Grandmother was a baker, my mother is a great baker so it's in my blood. The other reason is that cake is a comfort food and I like creating foods that make people feel good.

What is your favorite item to bake?
I love baking all cakes, but if I had to pick a favorite, it would be Red Velvet Cake.

Do you have a special ritual that you use while you are baking?
I don't have a ritual per se but I start the oven, grease my pans, and measure all my ingredients out and place them in small bowls before I start mixing anything. Depending on the type of cake I'm making, I like to race against the oven to see if I can completely mix the cake before the preheating session on the oven. I believe it's six minutes.

What is your inspiration to bake?
My inspiration is my love for baking and again, making people feel good.

*Please share with us a little about your Navy background.*
I started as an E-1 and was a Dental Technician onboard the *USS Puget Sound*. Throughout the years, I went to school at night until I was able to earn my AA (University of Maryland University College), then my BS (University of Maryland University College) then my MS (Rochester Institute of Technology) and then my MBA from the Naval Post Graduate School. I am currently in the Dissertation phase of my PhD in Conflict Analysis and Resolution from Nova Southeastern University.

Is there a baking nightmare.
A baking nightmare happened when I fell asleep while baking a cake. Needless to say, it was burnt so I woke up early the next morning and baked another one. Another nightmare happened when my cake broke in half when I tried to release it from the pan.

Any words of wisdom for aspiring bakers?
Regarding words of wisdom, never slam the oven door.
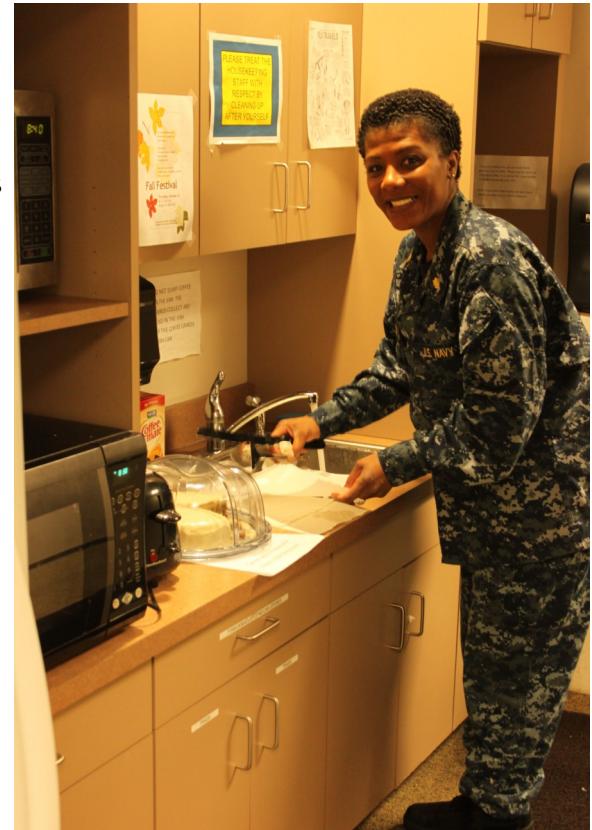
Lt. Cmdr. Lydia R. Robinson, Deputy Director, Health Services Strategies, and NMLC's Command Diversity Officer, enjoys baking and shares her delicious creations with anyone who happens to stroll through the kitchen on the right day and at the right time.

LOGISTICALLY *speaking*

SMALL BUSINESS PROGRAMS

WELCOME TO BIZ BUZZ !

Biz Buzz is where you will find what's happening with NMLC's Small Business Program Office, as well as general small business information and news you can use.

What's the BUZZ?

What's the *Buzz*? Effective 2 November 2011, and as a result of the Small Business Jobs Act of 2010, an interim rule has been published that now allows agencies the ability to set aside orders and blanket purchase agreements (BPAs) issued under multiple award schedules (MAS) (e.g., Federal Supply Schedule (FSS), GSA, VA) contracts at the Contracting Officer's discretion. In the past, this was not allowed and agencies were unable to set-aside procurements under FSS. The effect of the new ruling could have a very positive impact on increasing contract awards to small businesses and a further positive effect on reaching established small business goals.

Here is some further guidance:

Contracting Officers, *at their discretion*, may set aside orders and BPAs for small businesses and the following small business subcategories:

- 8(a) business development participants

- HUBZone small business

- Service-disabled veteran-owned small business (SDVOSB)

- Economically disadvantaged women-owned small business (EDWOSB)

Women-owned small business (WOSB)

Specific Set-Aside Eligibility Requirements - Contracting officers may only set aside certain orders for 8(a), Women-owned small businesses (WOSB) or Economically disadvantaged women-owned small businesses (EDWOSB) as follows consider the following:

To Set Aside Orders For...	Orders must...
WOSB/ EDWOSB	Not exceed $6.5 million for manufacturing ($4 million for all other orders) and be within scope of NAICS code industries specified by SBA.
8(a)	Exceed $6.5 million for manufacturing ($4 million for all other orders).
HUBZone/SDVOSB	No limitations.

What steps must an Ordering Contracting Officer take to set aside an order or a BPA under the Schedules Program? Agencies must take the following four steps:

Step 1 - Perform market research. Determine if there are small businesses capable of performing the desired work.

Step 2- *Incorporate clauses into Requests for Quotes (RFQs) (until Schedules are modified).* GSA Federal Acquisition Service (FAS) is in the process of modifying its existing vehicles to include all appropriate set-asides clauses. Contracting Officers can visit Contracts Online *(accessed through gsaelibrary.gsa.gov)* to view a listing of the Schedule contracts with their current clauses to see which Schedule contracts have been modified. Before all FAS contracts have been modified to incorporate set-aside

SMALL BUSINESS PROGRAMS

clauses, Contracting Officers shall incorporate the following FAR clauses, as applicable, in all RFQs:

- 52.219-13 Notice of Set-Aside of Orders (NOV 2011)

- 52.219-3 Notice of Total HUBZone Set-Aside or Sole Source Award (NOV 2011)

- 52.219-6 Notice of Total Small Business Set-Aside (NOV 2011)

- 52.219-14 Limitations on Subcontracting (NOV 2011)

- 52.219-27 Notice of Total Service-Disabled Veteran-Owned Small Business Set-Aside (NOV 2011)

- 52.219-29 Notice of Total Set-Aside for Economically Disadvantaged Women-Owned Small Business (EDWOSB) Concerns (NOV 2011)

- 52.219-30 Notice of Total Set-Aside for Women-Owned Small Business Concerns Eligible Under the Women-Owned Small Business Program (NOV 2011)

Step 3 - Include a statement in the RFQ for an order or BPA that will be set aside. The Contracting Officer should include the following language in the RFQ: This is a notice that this [insert either "order" or "Blanket Purchase Agreement"] is a total set-aside for [insert either "small business concerns" or specify a type of small business concern]. Only quotes submitted by [insert either "small business concerns" or specify a type of small business concern] will be accepted by the Government. Any quote that is submitted by a contractor that is not [insert either "a small business concern" or specify a type of small business concern] will not be considered for award.

Step 4 - *Use the same competition rules as provided in FAR 8.405, except limit consideration only to small businesses.*

Size of BPA/Order	Competition Strategy	Any special documentation required?
BPA/Order is over the Micro-purchase Threshold (MPT) but not over the Simplified Acquisition Threshold (SAT)	Agency posts a request-for-quote on E-Buy	No
	Agency considers reasonably available information about at least 3 small businesses	No
BPA/Order exceeds the SAT	Agency posts a request-for-quote on E-Buy	No
	Agency sends request-for-quote out to enough small businesses to receive quotes from at least three small businesses	No

For any questions concerning small business programs or if you have a small business topic of interest you would like to see featured in this article, please contact Ms. McReal at Mimi.McReal@med.navy.mil or via phone at (301) 619-3097.

SECURITY REQUIREMENT CHANGES FOR CONTRACTOR HEALTH CARE WORKERS

By Rebecca Tama, Deputy Director, Acquisition Management Directorate and Michele Cameron Chief, Contract Administration Division

What is the appropriate background investigation for individuals working under personal service contracts (PSCs) in Navy Medicine? The Chief of Naval Operations issued Manual SECNAV M-5510.30 in June 2006 to establish specific policy for the Department of the Navy Personnel Security Program. The guidelines in this Manual apply to all personnel working in Navy medical treatment facilities including military, federal government civilians, contractor personnel, volunteers and consultants.

SECNAV M-5510.30 classifies positions accessing information protected under the Privacy Act of 1974 as non-critical sensitive. This includes protected health information (PHI) and personally identifiable information (PII). Title 5, United States Code of Federal Regulations, Part 32 defines a noncritical-sensitive position as one whose occupant has the potential to bring about a serious impact or damage to national security.

The Bureau of Medicine and Surgery has determined that Navy Medicine currently does not fully meet the personnel security requirements outlined in SECNAV M-5510.30.

To comply with personnel security requirements, NMLC has drafted a clause entitled "Contractor Access to Federally Controlled Facilities and/or Unclassified Sensitive Information or Unclassified IT Systems" which is currently under review by BUMED and NAVSUP. Until final approval of the clause is received, the draft language is being incorporated into Section H of all current and future solicitations. When the clause is approved, it will be incorporated by modification into existing contracts for healthcare workers and included in all solicitations for healthcare

worker requirements.

Highlights of the personnel security requirements contained in the clause are as follows:

- All contract health care workers working at a federally controlled base, facility or activity will require a Common Access Card.

- Each contractor shall appoint a Security Representative to be the primary point of contact on any security matter.

Contractors who require access to DoD networks are categorized as IT-I, IT-II, or IT-III. The clause applies to contractors who require IT-II privileged access to a DoN or DoD unclassified computer/network. The IT-II level includes positions which require access to information protected under the Privacy Act which includes PHI and PII.

To obtain a favorable determination, each contractor employee must have a favorably completed National Agency Check with Local Credit Checks (NACLC) which consists of a NACI including a FBI fingerprint check plus credit and law enforcement checks. Each contractor employee will be required to complete an SF-86 *Questionnaire for National Security Positions* (or equivalent OPM investigative product), two FD-258 Applicant Fingerprint Cards and original Signed Release Statements. These documents must be provided at least 30 days prior to the individual's start date.

The Contractor's Security Representative shall be responsible for initiating reinvestigations as required and ensuring that background investigations remain current (not older than 10 years) throughout the contract performance period.

LOGISTICALLY *speaking*

If performance of the contractor employee's duties requires access to IT systems, the employees shall in-process with the Navy Command's Security Manager and Information Assurance Manager upon arrival at the Navy command and shall out-process prior to their departure upon completion of the individual's performance under the contract. Completion and approval of a System Authorization Access Request Navy (SAAR-N) form is required for all individuals accessing Navy Information Technology resources. The SAAR-N shall be forwarded to the Navy Command's Security Manager at least 30 days prior to the individual's start date.

The Contractor's Security Representative is responsible for ensuring that each individual employee pending assignment shall accurately complete the required forms for submission and shall screen the investigative questionnaires for completeness and accuracy and for potential suitability/security issues prior to submitting the request to the Navy Command's Security Manager. The Navy Command's Security Manager becomes responsible for the contracted health care worker's SF 86 once it is submitted and is responsible for routing the documents to the Office of Personnel Management.

"FY12 DON DAWIA Goals - How BUMED measures Up & Where You Fit In"

By Barbara Douglas-Rook

On November 4, 2011, Ms. Rene Thomas-Rizzo, Director of Acquisition Career Management (DACM), released a memorandum which established the Department of the Navy Defense Acquisition Workforce Improvement Act (DON DAWIA) FY12 DAWIA goals. The goals are more challenging than FY11 and continue to focus on enhancing the quality and professionalism of the Acquisition Workforce.

The two goals are certification levels and continuous learning (CL). Goal 1 - certification is to have 95% of Acquisition Workforce (AWF) members be certified to the level required by their position within allowable timeframes. Goal 2 - is to have 80% (increased from 75% in FY11) of AWF maintaining current CL certificates.

In light of the recent changes to contracting certification requirements, the first goal will, indeed, be a challenge to the workforce. Recognizing the difficulties in implementing the significant changes and the fact that some courses were unavailable, guidance was given this past September which extended the certification period from 24 to 40 months for those in the workforce pursuing certification on or before September 30, 2011.

There are currently 227 civilian acquisition workforce employees and 46 military acquisition officer billets in BUMED, of those 88% of civilians and 91% of military officers, are certified to required level falling short of the FY12 goal of 95%. The second goal regards CL certificates - the goal is to have 80% of workforce to have current certificates. Overall Compliance is at 71% again falling short of the FY12 goal of 80%.

In summary, BUMED's acquisition workforce must focus on certification efforts, especially in the career field of purchasing. To meet the intent of the new goals (having the most professional and quality workforce possible), we must continue to request training, utilizing all the resources available and ensure continuous learning points are recorded in a timely manner.

Is it time to check your DAWIA status? Go to eDACM now: https://www.atrrs.army.mil/channels/navyedacm/DawiaStatus/Dashboard/Detail

SECURITY REQUIREMENT CHANGES FOR CONTRACTOR HEALTH CARE WORKERS

An unfavorable determination made by the Navy is final (subject to SF 86 appeal procedures) and denial of physical or system access does not relieve the contractor from the requirement to execute performance under the contract within the specified timeframes. If a contract health care worker cannot receive a suitable background investigation, the contractor must provide a health care worker who can.

The Navy Command's Security Manager may authorize issuance of a CAC card and interim access to a DoN or DoD unclassified computer/network upon a favorable review of the SF-86 questionnaire and advance fingerprint results. If the results of the investigation are received and a favorable determination is not made, contractor employees working on the contract under interim access shall be removed immediately.

In summary, the Department of Defense policy is that ALL individuals who have access to information protected under the Privacy Act must be assigned to positions that are noncritical sensitive. All persons occupying a noncritical sensitive position must undergo a NACLC investigation submitted on an SF86 and the investigation will be conducted against the national security adjudicative standards. The Navy Command's Security Manager may authorize issuance of a CAC card and interim access to a DoN or DoD unclassified computer/network upon a favorable review of the SF-86 questionnaire and advance fingerprint results.

Current NMLC contracts for health care workers include a requirement for completion of SF-85P, *Questionnaire for Public Trust Positions*. Until the new clause is approved and modified into existing contracts, the requirement remains completion of an SF-85 and not an SF-86. The Contract Administration Division 's (CAD) plan is to modify all existing contracts beginning with the most recently awarded to incorporate the clause once approval is received. It will take approximately twelve months to complete all the modifications.

In the event Navy Security Managers at a facility require an SF-86 for access and the contract terms and conditions stipulate an SF-85P, the Contracting Officer's Representative or Contractor should immediately contact the Contracting Officer for guidance. These issues will be handled on a case-by-case basis until all the modifications are complete. If the Navy Security Manager requires an SF-86, the ability to issue a CAC card and grant interim access to the network should mitigate delays in health care providers coming aboard and thus not drastically impact the quality and availability of healthcare for active duty personnel, military dependents, and other DoD beneficiaries throughout Navy Medicine.

Appointing Contracting Officer's Representatives (CORs) -

More Important than You Think

By Melanie Muscar
Chief, Services Contracts Division

It's no surprise that acquisition planning can make or break procurements. Defining the need early, making market savvy decisions about sourcing and providing efficient funds flow can have drastic implications on an acquisition's timeline. But did you know that so can nominating a COR? If a procurement is required to have a COR appointed, not submitting a COR nomination letter can hold-up an award and delay the start of services -- impacting patient care. So, what's the big deal?

The DFARS (DoD Federal Acquisition Supplement) Procurement, Guidelines and Instructions (PGI) 201.602-2(i)(A) requires that *"for contract actions for services awarded by a DoD component or by any other Federal agency on behalf of DoD, contracting officers shall designate a properly trained COR in writing before award."*

This has been a requirement for some time, but now people are really starting to pay attention to whether contracting agencies are complying with it. Naval Supply Systems Command (NAVSUP) issues NAVMEDLOGCOM's procurement authority and even has an instruction for CORs which provides guidance addressing the nomination, appointment, responsibilities, limitations of authority, and oversight of a COR. NAVSUP verifies compliance with the PGI regulation cited above by requiring a quarterly report measuring the number of appointed CORs. The most recent report showed that NAVMEDLOGCOM is far from being in compliance with the metric – that 100% of all service contracts requiring a COR have a COR appointed. In effort to become compliant, a COR nomination letter will now be required as a part of the requirements package at the start of an acquisition.

Between the kick-off meeting and turnover meeting, a NAVMED-LOGCOM healthcare analyst will work with the requiring activity to obtain an approved statement of work, a market survey/ Independent Government Cost Estimate, a funding document, and now a COR nomination letter (if required). New base MATOs and SATOs, new agency contracts and new Individual Set-Aside contracts will be subject to this new requirement. New TOPRs against existing base MATOs and SATOs should already have appointed CORs and are exempt.

As outlined in NAVSUP's COR instruction, NAVSUPINST 4205.3D, the nominating official is the Commander/Commanding Officer or designee of the requiring activity and is responsible for submitting a written COR nomination letter to the contracting activity. If you're at a requiring activity that has a long chain of command and it generally takes more than a week or two to get your CO's signature, it is im-

COR's Con't

portant to note that the nominating official can be a designee – this will likely drastically reduce the amount of time it takes to get a nomination letter signed.

The nomination letter shall outline the nominee's technical qualifications and functions to be performed. A complete nomination letter shall also include, as an enclosure, any required training certificates verifying the nominee has been properly trained to perform as a COR. A requirements package will not be considered complete unless it contains the COR nomination letter. For further information, please contact your NAVMEDLOGCOM healthcare analyst or contracting officer.

References: DFARS PGI 201.602-2 (i)(A), NAVSUPINST 4205.3D, NAVSUPINST 4200.81F

Unauthorized Commitments: Trends for FY 2011

By Kathryn Skowronski, Team Leader, Contract Support Division

An Unauthorized Commitment is defined by the FAR as an agreement that is not binding solely because the Government representative who made it lacked the authority to enter into that agreement on behalf of the Government. An Unauthorized Commitment is a serious issue and the procedures for ratification of that Unauthorized Commitment can be long and arduous. Thus, Unauthorized Commitments, also known as UN-COMs or UACs, are monitored on a regular basis in an effort to reduce the number of occurrences.

There were twenty-three (23) ratifications totaling $153,998.64 processed in fiscal year 2011 for BUMED activities. This represents an increase in total actions, but a decrease in dollars compared to fiscal year 2010 which processed twenty (20) ratifications totaling $212,555.68. Poor turnover of responsibilities and a lack of communication were the primary contributing factors leading to Unauthorized Commitments in FY11. While separation of function is an important part of the Government's acquisition process, adequate communication between initiator, budget, and contracting is crucial. When communication is lacking, assumptions are made which lead to costly errors. In all cases, the department initiating a purchase must make sure the comptroller has funded the request and the contracting officer has issued an order before contacting the vendor. While not as prevalent, another contributing factor is a lack of situational awareness with respect to contract status. In other words, a UAC resulted when the individuals involved assumed a contract [still] existed to cover the need, when in fact the contract had expired or the quantities had been expended.

The following are suggested best practices to reduce the number of Unauthorized Commitments for FY 2012. First, each activity should prepare a written Standard Operating Procedure detailing the procurement procedures for that activity. In a high turnover environment, this go-to guide can facilitate communication and reduce mistakes. Second, increased communication between the end user and the budget or finance office will ensure that the funding is being processed for the requirement.

LOGISTICALLY *speaking*

News

CORs Corner

Third, increased communication between the end user and the contracting or ordering office will ensure that all aspects of regulation and law are considered. And lastly, training on Unauthorized Commitments increases organizational awareness of the problem and helps to prevent it in the future. If each activity follows the suggestions above, Unauthorized Commitments can be significantly reduced in the future.

New BUMED Ordering Officer Guide for E-commerce Contracts Published

By Gilbert Hovermale, Director, Acquisition Management Directorate

Prime Vendor (PV) and electronic catalog (ECAT) ordering officers have a new resource. A new Ordering Officer Guide for Defense Logistics Agency (DLA) E-Commerce Contracts was signed by the Deputy Chief, Installations and Logistics, on 31 October 2011 and published on eKM on 02 November 2011. The new guidance replaced a 23 December 2008 policy memo, BUMED Ordering Officer Requirements. The new guidance was coordinated with the Naval Supply Systems Command and DLA Troop Support and complies with ordering officer guidance and policy issued by both organizations.

The new guide specifies appointment and training requirements for individuals authorized to issue PV and ECAT orders above the micropurchase threshold (currently $3,000). These individuals must be properly appointed on a SF-1402 which specifies the limits of the ordering officer's authority. Naval Medical Logistics Command (NAVMEDLOGCOM) is working with the cognizant Fleet Logistics Centers to get new authority letters specifying PV and ECAT issued for BUMED activities. Minimum training for ordering officers is a short Defense Acquisition University (DAU) on-line course, Simplified Acquisition Procedures (CLC-005). Ordering officers must also take annual ethics training and be familiar with the BUMED ECAT Standard Operating Procedure.

Ordering officers must use "fair opportunity for consideration" when issuing ECAT orders above the micropurchase threshold. The same applies for purchasing medical equipment on PV. Fair opportunity basically means that it is the Ordering Officer's responsibility to compare products from all ECAT vendors who have the potential to meet the Government's needs and select the one that offers the best value to the Government.

The Ordering Officer has broad discretion in the factors he or she considers when making the best value decision, including price, equipment features, service support, warranty, trade-in considerations, and past history with the vendor. The Ordering Officer must document which vendors' products were considered and why the selected vendor was the best value in a brief memorandum. If the requestor identifies a particular product to the exclusion of all others, the file must be documented as to why that product is the only one that will satisfy the Government's needs. Ordering officer records and purchase documentation requirements are described in the guide, as is the responsibility for review of ordering officer records.

The new Ordering Officer Guide contains restrictions on the purchase of medical equipment on PV. BUMED ordering officers may not purchase medical equipment that has the potential to be added to any DOD data network, that has a unit price greater than $5,000, or that requires other than Operation and Maintenance (O&M) funding. BUMED ordering officers may not split a requirement that should be purchased as a system in order to circumvent competition or avoid the use of Other Procurement (OP) funds. BUMED ordering officers purchasing an initial medical capability for a ship may use funds provided for that purpose (OPN, SCN). BUMED ordering officers may not purchase medical equipment maintenance off PV. BUMED ordering officers may not use the Alternate Commercial Product Ordering Procedures (ACPOP) feature of PV.

Fair opportunity procedures are not required for purchase of items other than medical equipment on PV (pharmaceuticals, medical/surgical consumable items, for example); however, as the contracting office of record for PV, DLA-TS expects ordering officers to do due diligence in choosing best value products that meet their requirements.

In addition to eKM, the Ordering Officer Guide for Defense Logistics Agency (DLA) E-Commerce Contracts will be published as part of the FY12 Logistics Guidance on NAVMEDLOGCOM's Mil/Gov website. You may also obtain a copy by sending an email request to Support @med.navy.mil.

> **If the requestor identifies a particular product to the exclusion of all others, the file must be documented as to why that product is the only one that will satisfy the Government's needs**

Above, Dustoff Medivac, Bagram Airfield.

Below FOB SHANK Field Surgical Team (FST) Ward .

DMMPO Participates in CENTCOM COCOM TARA visit 2011

By Cmdr. John Ware

The DMMPO participated in the 2011 CENTCOM Combatant Command Technology Assessment and Requirements Analysis (COCOM TARA) visit that encompassed reviews of several Medical Treatment Facilities (MTF) throughout the CENTCOM AOR. These MTFs included the Role III hospitals in Kuwait, Qatar, Bagram, Kandahar, and Dwyer. They also visited the Forward Surgical Teams in Tarin Kowt, Forward Operating Base Salerno, and Forward Operating Base Shrank.

The CENTCOM team was comprised of the Army Surgeon General Clinical Consultants from Radiology and Pharmacy, USAMMA representatives for Nursing and Biomedical maintenance, and CDR John Ware. CDR Ware represented the DMMPO office and was the joint service representative for the clinical laboratory community.

The purpose of COCOM TARA team is to assess and identify requirements for deployed medical facilities in support of current operations. The objective of each site visit is to interview departmental staff, observe patient-flow patterns, evaluate quality of service, evaluate the condition and utilization of existing equipment, provide a strategic replacement plan for equipment, recommend improvements in operations, facilities, staffing, workflow, and to discuss clinical operations. This ensures that our medical facilities have the equipment they need to support both resuscitative and sustainment healthcare operations within a mature Theater. The COCOM TARA provides recommendations to the COCOM Surgeon with respect to the level of technology needed to perform their clinical mission and save lives.

LOGISTICALLY *speaking*

DMMPO assists the Committee on Tactical Combat Casualty Care (CoTCCC) with recommending core Individual First Aid Kit (IFAK) and Medic Aid Kit

By Air Force Major Brandi Ritter

The (CoTCCC), founded in 2001, develops guidelines for medical treatment in the tactical pre-hospital setting. In March 2009, the Assistant Secretary of Defense for Health Affairs recommended that the Military Services utilize TCCC guidelines as the basis for training combat medical personnel to manage trauma in the tactical pre-hospital setting. Subsequently, each Service implemented policies directing TCCC curriculum changes to be immediately incorporated into all medical courses and programs governing trauma care on the battlefield.

In early 2010 the CoTCCC and the Defense Medical Materiel Program Office (DMMPO) conducted a review of the guidelines and identified the medical materiel necessary to perform all treatment recommended in the guidelines. The DMMPO assisted the CoTCCC in recommending a core Individual First Aid Kit (IFAK) and Medic Aid Kit to ensure the correct tools are available to the individuals carrying out the tasks identified in the guidelines.

The recommended medical items were compared to the existing IFAKs and medic kits assemblage listings and a map and gap conducted.

Proposed new Air Force IFAK

During the initial map and gap of the different kits, one hundred percent of the Service IFAKs and medic kits were missing essential items required to effectively carry out the treatment guidelines. The DMMPO and the CoTCCC collaborated with the Service logistics agencies in order to correct the identified gaps. Extensive efforts were instituted by each service in order to rapidly equip the IFAKs.

Currently, each Service IFAK is either fully equipped with the necessary medical treatment items or a plan is in place ensuring the medical devices are added once funding is secured. The equipment changes implemented by the US Marine Corps and the US Air Force total over $38 million. The final costs for updating the Army and Special Operations kits were not available at this time.

This allowance standard update has been a significant undertaking. Each agency and individual involved should take pride in knowing they had a part in ensuring every soldier, sailor, airman and marine has the necessary medical devices to conduct exemplary medical care on the battlefield, leading to the highest battlefield trauma survival rate in history.

LOGISTICALLY *speaking*

Naval Ophthalmic Support and Training Activity (NOSTRA)

Hospital Corpsman Second Class Erick I. Martinez-Abril was awarded the Navy and Marine Corp Achievement Medal for his selection as the Military Health System, Optical Fabrication Enterprise "Fabricating Optician of the Year" for 2011. Selected from among an exceptional group of Army and Navy Opticians assigned to 26 Optical Fabricating Labs world-wide, Petty Officer Martinez-Abril facilitated implementation of Lean management processes which contributed to the efficient production of over 459,000 pairs of military prescription eyewear. He also volunteered his personal time promoting Sailorization, Staff Education, and fostering good community relations in the Hampton Roads area.

Hospital Corpsman Third Class Adam G. Walters was selected as NOSTRA and NMLC Blue Jacket of the Year FY-11. Petty Officer Walters contributed to the fabrication of more than 198k pairs of optical devices with a cost value of $3.9M. Due to his exceptional expertise, he was selected to represent the command in the National Federation of Opticianry Schools College Bowl. He also provided optical support during the Naval Academy's Induction Day and the Marine Corps' Operation Bulldog, fabricating more than 300 pairs of eyewear.

> Below, NMLC Commanding Officer Capt. Poindexter frocks HM1(FMF) Rowell S. Pasion, to his current pay grade.

LOGISTICALLY *speaking*

NMLC Detachment, Pirmasens, Germany

Class VIII logistics has the power to influence not only the battlefield but also the medical care warfighters receive downrange. The U.S. Army Medical Materiel Center-Southwest Asia (USAMMC-SWA), the Theater Lead Agent for Medical Materiel, is the primary source of Class VIII supply for the CENTCOM AOR. USAMMC- SWA contributions to the warfighters are immeasurable, but as operations in Iraq and Afghanistan decrease, the Army is looking to improve overall efficiency with its current logistical

Lt. Cmdr. Rebecca Gels, Detachment Pirmasens Officer in Charge and the NMLC Pirmasens Team show pride in their award winning door during the USAMMCE door decorating contest.

Detachment Pirmasens earned the coveted winning door during USAM-MCE's door decorating contest.

system. As of December 1, 2011, The U.S. Army Medical Materiel Center – Europe (USAMMC-E) will begin to take control over 1,400 slow moving/low volume lines from USAMMC-SWA. These items were previously identified. The transition continues, 15 January 2012, USAMMC-E will take over direct support to the Role 3 in Bagram. USAMMCE will evaluate the transition for a period of time to understand the overall impact of the additional workload. The plan is to continue to transition Role 3's throughout Afghanistan providing direct support to the warfighter from Europe vice Qatar.

Why do this? This transition will avoid the costly practice of having to move piles of excess material that would result later when transitioning units away from USAMMC-SWA from direct support (specifically Role 3 units with highly specialized low volume requirements).

Therefore, over the next couple of months, USAMMCE-SWA will transfer the overall materiel management and shipping of items ordered less often to the United States Army Medical Materiel Center, Europe, as well as direct support for the Role 3's throughout Afghanistan.

A Picture is Worth A Thousand Words

By Lt. j.g. Raul Cuevas, OIC NEMSCOM FHAT

Navy Medical Logistics Command (NMLC), in an effort to revitalize training capabilities of Naval Expeditionary Medical Training Institute (NEMTI) organizes a training evolution to occur at NEMTI headquarters in Camp Pendleton, CA. As the overall Navy experts of expeditionary hospital deployment, the Navy Expeditionary Medical Support Command (NEMSCOM) was tasked by NMLC to deploy a partial expeditionary medical field hospital (EMF), along with subject matter experts to support this mission and the training of NEMTI personnel.

Mission

NEMSCOM was tasked with the deployment of a partial EMF in order to put together a 20-bed field hospital with 10 medical divisions from 09 - 14 December 2011, to prepare with upcoming NEMTI training in January 2012.

Deployment Tasking

Tasking includes the deployment of a 20-bed EMF hospital. The Fleet Hospital Assistance Teams (FHAT) shall provide technical expertise to assist hospital staff with the building and activation of Deployable Medical Systems (DEPMEDS). The Team will assist the hospital command staff with the activation, and once operational capability is achieved, the FHAT will facilitate transfer of material accountability and redeploy.

Top row from left to right, pictures 1, 2, &3, **Seabees work alongside NEMTI personnel and Reservist to construct fleet hospital frame. Picture 4. Mr. Ramdath Chandoo explains frame connections to Reservist from Great Lakes. Pictures 5 & 6, Seabees work alongside NEMTI personnel and Reservist to erect fleet hospital Wing 1**

PUBLIC AFFAIRS HAPPENINGS

NEMTI and Reservists align the fleet hospital frame.

NEMTI and Reservists install the interior lining and flooring in Wing 2.

HM2 Albrecht directing NEMTI personnel on where to stuff the medical equipment.

NEMTI personnel conduct an inventory and help with medical equipment setup.

**Reservist continue with medical equipment setup.**

HM2 Abrecht conducts final walkthrough of patient room in Wing 2.

The photos on the previous pages illustrate the construction process of the below Expeditionary Medical Facility. Mission Complete!
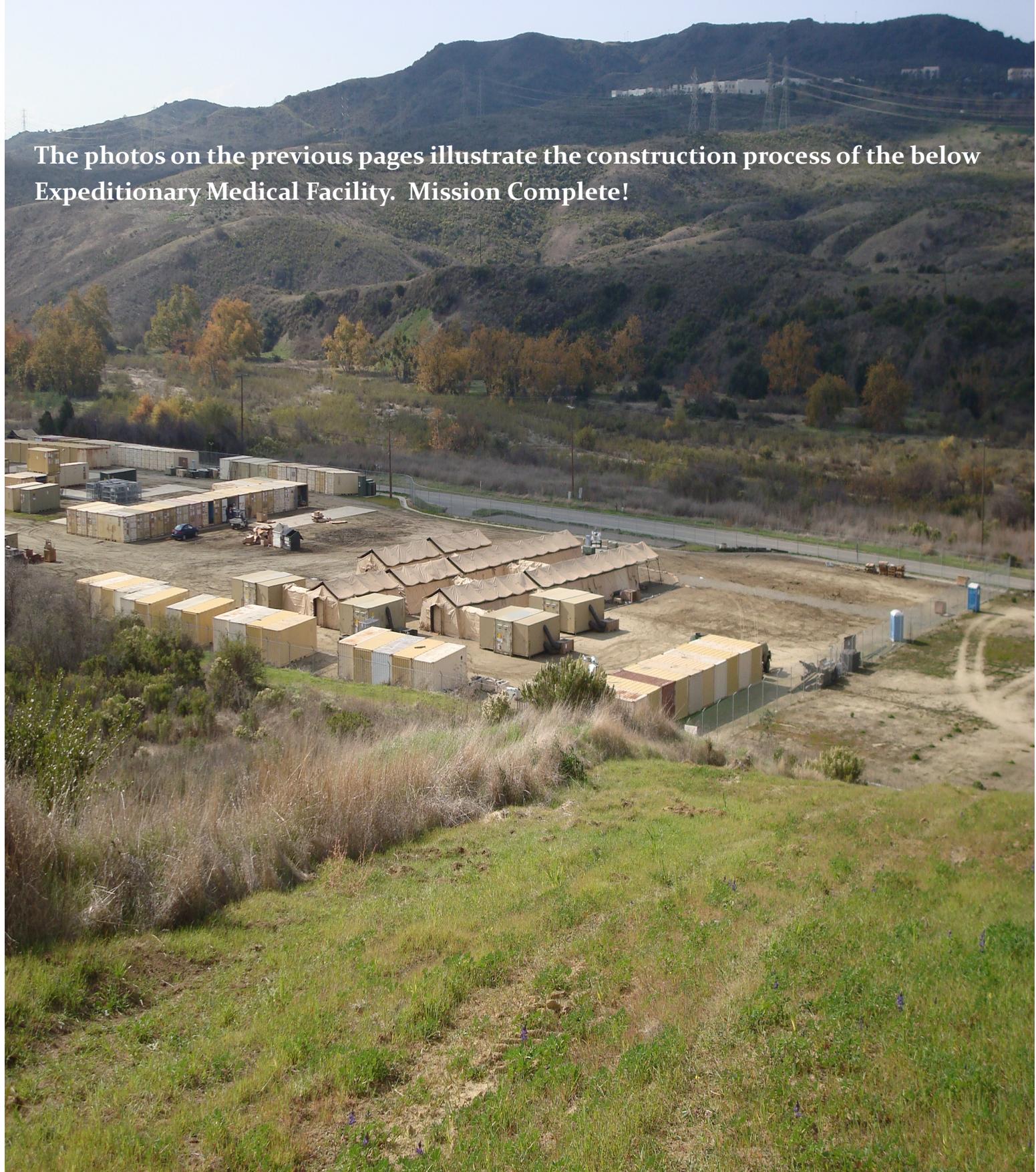
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